Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 20, 2017	2017_370649_0009	005077-17	Critical Incident System

Licensee/Titulaire de permis

DRS PAUL AND JOHN REKAI CENTRE
345 SHERBOURNE STREET TORONTO ON M5A 2S3

Long-Term Care Home/Foyer de soins de longue durée

DRS. PAUL AND JOHN REKAI CENTRE
345 SHERBOURNE STREET TORONTO ON M5A 2S3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JULIEANN HING (649)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 24, 27, 28, March 1, 2, 3, 6, and 7, 2017.

The following intake were inspected concurrently with this inspection:
Log #005077-17 related to altercations and other interactions between residents

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing Services (DNS), Director of Resident Care (DRC), Resident Assessment Instrument (RAI) Coordinator, Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), and residents.

During the course of the inspection , the inspectors toured the home, observed staff to resident interactions, reviewed health records, reviewed the home's staff training records, staff schedules and relevant polices and procedures.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that that the home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

On an identified date in 2017, a critical incident (CI) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) stating that resident #013 was abusive to co-resident #001 on an identified date in 2017.

Interview with resident #001 revealed on an identified date in 2017, he/she witnessed resident #013 exhibits an inappropriate behaviour toward resident #001. Resident #001 went to his/her room and called the police. The police came and spoke with both residents.

Interview with resident #013 revealed that he/she could not recall how he/she had responded to resident #001 on an identified date in 2017. Prior to this incident there was a history of concerns between the residents. Resident #013 told the director of nursing services (DNS) that he/she exhibits the identified responsive behaviour to upset resident #001. During the time of the incident there were no interventions in place to ensure resident #001's safety.

Interview with PSW #128 revealed that on the day of the incident while he/she was in a resident’s washroom heard an identifiable concern and looked out to see what was happening. PSW reported that residents #001 and #013 were observed in an identified area and in an identified manner. PSW #128 observed both residents separated and confirmed that he/she did not report the incident to the nurse.

Interview with DNS and director of resident care (DRC) revealed that it is the home’s expectation that staff immediately report any abuse between residents to their charge nurse on the unit. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that that the home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents including, identifying and implementing interventions.

On an identified date in 2017, a CI was submitted to the MOHLTC stating that resident #013 was abusive to co-resident #001 on an identified date 2017.

A review of resident #013's written plan of care did not indicate any interventions to minimize the risk of altercations between these two residents.

Interviews with registered practical nurse (RPN) #108 and PSW #124 revealed that resident #001 and resident #013 have an identifiable interaction and RPN revealed when resident #013 passes resident #001 he/she may make exhibit an identified responsive behaviour toward resident #001 that will make him/her upset. They revealed that these identified altercations have been happening since an identified time in 2016 and occurred most frequently when there is no one else around. RPN, PSWs #124, #128 and #130 revealed that no monitoring is done while the residents are off the unit.

Interview with resident #013 revealed that he/she had many altercations with resident #001 and stated that the altercations happen when no one else is around.

Interview with DNS and DRC revealed that the residents are not being supervised while off the unit and no interventions had been implemented in resident #013's written plan of care to minimize the risk of identified altercations between the residents. [s. 54. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents including, identifying and implementing interventions, to be implemented voluntarily.

Issued on this 12th day of May, 2017

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.